In Case No. 2, you will see that with the cystoscope a tumor was diagnosed which the subsequent operation failed to reveal. The blame for this cannot be laid on the cystoscope, but rather upon the operator, and yet there undoubtedly was something tumor-like protruding into the bladder at each of the two examinations. I was at a loss just how to explain this circumstance until recently, when my friend, Dr. L. Bolton Bangs, of New York, in a paper on "Some of the difficulties in the use of the cystoscope," read before the Surgical Section of the New York Academy of Medicine in November, 1891, referred to a similar experience of his own. His diagnosis of bladder tumor was confirmed by Dr. Willy Meyer, another experienced operator with the instrument. He says: "Upon the superior and lateral wall of the bladder on its left side is seen projecting into the viscus a conical-shaped body, sessile, irregular in outline, and of deeper hue than the surrounding mucous membrane." While after the operation he says: "At the place where the tumor was supposed to have been seen prior to the operation, there was nothing but the thickened, softened, and hyperæmic mucous membrane as seen elsewhere within the viscus." His explanation, and with it I entirely agree, is that it was a fold of the anterior bladder wall. When we think how the mucous membrane of the bladder folds up when the organ is empty, it will not be difficult to see how this fold may have been projecting still into the viscus. It behooves us, therefore, to be more careful and more thorough in our examinations. In his case, as in mine, there was other trouble present, which the operation relieved, and was sufficient cause to justify the operation; the operator would have felt humiliated on not finding that for which he was looking and had diagnosed as existing.

In Case No. 3, the size of the calculus is proof that a longer time than five years must have elapsed since the nucleus of the stone was formed, yet no symptoms were evidenced until five years ago. It is another striking evidence that stone may exist without symptoms, or at any rate symptoms of any severity. Since reading this paper another case has been sent me in which no symptoms of stone existed excepting when from cold or other causes a cystitis was produced. Two years ago it was found, and gave him no trouble until quite recently, when from a cold he developed an acute cystitis. The specimen of the kidney with so large a stone (over one-half inch in diameter) and symptoms so recent is peculiar. When I made the *post mortem* and found the large mass of hardness surrounding the kidney I felt sure that it was cancerous, but the explanation is clear on dissection, and seeing where a perforation exists with infiltration into the cellular fat and subsequent inflammation. I do not propose to enter into the discussion of suprapubic versus perineal lithotomy. There are cases in which each is the better, but I am of the opinion that the high operation is the one that should be resorted to by any operator who is not thoroughly experienced in the lateral. It is the operation for the surgeon who has not seen or performed the lateral several times. There is no danger of wounding any part or organ that surgical cleanliness and care cannot immediately rectify; while in the lateral large vessels are in the immediate vicinity; the spermatic vessels and other parts are in danger, to injure which is to leave a permanent disability on the patient. The best direction for the abdominal wound and its treatment are yet unsettled questions. I believe that the straight cut with a partial transverse division of the rectus is the one that will give the best after results; except in the case of an exceedingly large and fat abdomen, when the transverse may be resorted to.

The wound of the bladder: Whether to leave it open or stitch it up has been brought before the profession of Ontario at the meeting of the Ontario Medical Association in June last by Dr. Groves, of Fergus. I was unable to hear the paper, but from what the doctor told me I believe he advocates closing the bladder and draining through the urethra. I do not agree with that. In the first place, the constant passing of instruments is injurious to the urethra and irritating to the neck of the bladder, and liable to set up an inflammatory process which we need only to think of to dread. Sir Joseph Lister drained through an opening made from within outward in the perineum. In the second place, the bladder wound must of necessity be drawn absolutely together in every part, or there will be infiltration. Should the drainage be in any way imperfect through the urethra, I prefer to leave the